

VBPQIAC Workgroup 2 – Leveraging Multi-Payer Data

Policy Issue:

In Texas, there are a number of health care payers, including the Employees Retirement System (ERS), Teachers Retirement System (TRS), Texas Department of Criminal Justice (TDCJ), Medicare, Medicaid, and commercial payers. Commercial payers include market-based plans, fully-insured employer group plans and other plans that are self-insured by large employers and are operated by third-party administrators or administrative service organizations. It is challenging to align value-based payment and quality improvement efforts across these major payers of health care without timely, transparent, comparable data and common measures.

During the past three legislative sessions, Texas has encouraged cross-agency collaboration in the use of health care data. Most recently, the state directed the Center for Healthcare Data at the University of Texas Health Science Center at Houston School of Public Health (UT Data Center) to conduct data comparisons, resulting in its receipt of claims data from the largest state-funded payers.¹

Multi-payer data can be a powerful tool to enable data-driven approaches to improving population health, including understanding cost-drivers, factors that lead to more or less favorable outcomes, and other variables that affect the Texas population. Access to robust multi-payer data can inform next steps to align payment reform efforts, improve quality and outcomes, increase transparency of costs, and reduce the cost of care.

Recommendations:

1. Texas should build on the multiple legislative sessions of direction to encourage collaboration in the use of health care data by:
 - a) Extending the term of the 10.06 rider for cross-agency collaboration for another five years, maintaining the services of the UT Data Center.
 - b) Directing remaining state funded health plans and health services to participate in the Rider 10.06 cross-agency collaboration, specifically the state-run hospitals (including psychiatric hospitals) and state supported living centers, juvenile justice health system, and employer sponsored health plans for state colleges and universities.
 - c) Requiring the agencies involved in the 10.06 rider to permit their data to be included in aggregated multi-payer analyses and reporting activities conducted by the UT Data Center.
 - d) Adding additional sources of data to the UT Data Center – State leadership should explore how to strategically partner with additional commercial payers, including self-insured payers and county indigent care programs, so that their data could be included in the UT Data Center as well.

¹ 2020-21 General Appropriations Act, Article IX, Section 10.06 (H.B. 1, 86th Legislature, Regular Session, 2019)

- e) Directing that data aggregated by the UT Data Center, including state agency data and data from other payers who have provided authorization, be shared at a de-identifiable level through a Public Use Data File (PUDF). An Application Programming Interface (API) should be developed and made available as one way of accessing the PUDF, in addition to a streamlined request process similar to that used for the Texas Health Care Information Collection (THCIC).
 - f) Exploring price and utilization variation among providers for similar services, both within metro areas and across the state, to identify instances and programs where savings can be achieved without sacrificing quality.
 - g) Directing UT Data Center to aggregate all available clinical, claims, pharmacy, cost, and quality data regarding specific high cost/high prevalence conditions, such as diabetes, to develop additional web features and de-identified data files for public and research use.
 - h) Exploring federal funding opportunities, such as those offered by the Center for Medicare & Medicaid Innovation, that advance value-based payment (VBP) and that are enabled by access to multi-payer data.
2. Texas should identify new and expanded use cases for the Texas Healthcare Learning Collaborative (THLC) Portal as well as analyze potential use cases for aggregating data from the THLC, the UT Data Center, the Texas Health Care Information Collection, and any other data sources that could prove beneficial. Texas should develop an implementation strategy for the most valuable use cases that leverages the strengths of these existing data sources while minimizing duplication of state resources.

Discussion

Analysis of multi-payer data in a de-identified way can increase understanding of cost drivers, outcome measures, and other variables that affect the Texas population. Such analysis can be used to advance alignment of value-based payment and quality improvement efforts across major payers of health care.

A number of states have recognized the promise of multi-payer claims data and have begun implementing all-payer claims databases (APCDs):²

- 18 states have existing APCDs
- 3 states are currently implementing APCDs
- 5 states have voluntary efforts

Interagency Data Sharing and the UT Data Center

Texas is among the states considered to have a voluntary APCD. Three consecutive sessions of legislative direction aimed at interagency data coordination to improve quality among state-funded programs have resulted in the Center for Healthcare

² All Payer Claims Database Council: <https://www.apcdouncil.org/state/map>

Data at The University of Texas Health Science Center at Houston School of Public Health (UT Data Center) receiving claims data from the largest payers in the state. Most recently, the 2020-21 General Appropriations Act, Article IX, Section 10.06 (H.B. 1, 86th Legislature, Regular Session, 2019) directs HHSC to coordinate with DSHS, ERS, TRS, and TDCJ to compare health care data, including outcome measures, to identify outliers and improvements for efficiency and quality that can be implemented within each health care system.

To administer the data comparison, Section 10.06 directs HHSC to work with the UT Data Center for data analysis, including individual benchmark and progress data for each agency. Section 10.06 also requires collaboration on the development and implementation of potential value-based payment strategies, including opportunities for episode-based bundling and pay for quality initiatives.

Opportunities to Build on Texas' Multi-Payer Data

The UT Data Center now holds claims data for most of the state's insured residents, including those insured by Medicare, Medicaid, ERS, TRS, TDCJ, and commercial payers. The Center also has some electronic medical records data and several public use data files of aggregated health events data and survey data.

Currently, the UT Data Center offers services related to health care data analyses and reporting to state entities, qualified researchers, non-profit organizations, institutions and foundations, and other clients with a non-proprietary interest in health care costs and quality. The UT Data Center has also used the information it collects to develop The Health of Texas Dashboard,³ which is a publicly available display of various summary-level data on all of Medicaid clients and a significant portion of Medicare and commercial covered lives down to the 3-digit zip code. The UT Data Center would need legislative direction to include ERS and TRS in the aggregate data for Health of Texas. The specific dashboards include:

- Drug and medical costs relative to the average annual total cost per member
- Utilization of ED visits, inpatient and observation stays, outpatient facilities, professional visits, and readmissions
- Prevalence of chronic diseases, such as asthma, diabetes, hypertension, and cancers, and autoimmune conditions and epilepsy
- Select quality measures related to diabetes, COPD, and asthma
- 3M clinical risk groups
- Social determinants of health, including overall scores and composite scores on access, health behaviors, health outcomes, physical environment, and social economic environment

While the amount of data the UT Data Center currently possesses is significant, the UT Data Center lacks some sources of state payer data that could lend additional insight into specific populations, including state hospital data, state supported living center data, juvenile justice data, and data for university employee health

³ <https://sph.uth.edu/research/centers/chcd/health-of-texas/?s=1>

insurance paid outside of TRS. Additionally, commercial payer participation is voluntary, and Texas' multi-payer data effort would benefit from strategic partnerships with additional commercial payers, especially those that would include specific and accurate information related to charges and payments and provider identification. Patient identifiable data would be useful as well, and the UT Data Center has been audited and certified in its privacy and security practices to protect such data. Patient identifiable data would be encrypted and only used when required and with Institutional Review Board (IRB) approval.

The Texas Health Improvement Network (THIN)⁴ provided data-related recommendations in a report released March 2019 titled *Facilitating Use of Data to Drive Population Health in Texas*.⁵ The report includes a variety of recommendations for data sharing from the Texas Health Care Information Collection (THCIC), Medicaid, and Vital Statistics data, including recommendations pertaining to:

- Removing statutory barriers for sharing identified public health data within and across state agencies (e.g., HHSC, DSHS, ERS, TRS, TDCJ) and local health departments.
- Improving quality, timeliness, and utility of data held by state agencies through initiatives such as standardizing some public reports and data query tools, standardizing processes for public and interagency requests for data sharing, standardizing data use agreements, and establishing circumstances under which provisional data is acceptable for more timely access to data.

In a similar spirit to the THIN recommendations, there is opportunity to expand upon the excellent analytics conducted at the UT Data Center by enabling other researchers throughout the state to explore their own research questions using state payer claims data. The potential applications of the data available at the UT Data Center could be greatly expanded by creating a public use data file (PUDF) that enables the public and researchers to download and manipulate a significant set of de-identified state payer claims data for their own analyses. In addition to facilitating capacity for the broader research community to explore what questions Texas' multi-payer data could address, a PUDF would diminish administrative burdens on the part of state agencies and the UT Data Center in responding to data requests and expedite access to data for researchers who otherwise might have to await the results of a data request review process. A streamlined data request process for any data not available in the PUDF could be established.

The PUDFs of hospital discharge data available through the Texas Health Care Information Collection (THCIC) provides a good public data access model.⁶ THCIC has a significant amount of PUDFs available for free download directly off the

⁴ Created by H.B. 3781, 84th Legislature, Regular Session, 2015

⁵ https://utsystem.edu/sites/default/files/sites/texas-health-journal/new%20site/THIN_Facilitating-Data-Use-For-Population-Health_Mar2019.pdf

⁶ <https://www.dshs.texas.gov/thcic/>

website. There is also a well-defined process for interested parties to request more recent hospital discharge PUDFs using a form and common data use agreement

The Texas multi-payer data holds great promise to be used in varying ways by policymakers, state agencies, researchers, health care consumers, payers, and providers to gain insights into health care quality, outcomes, and costs. The legislature could provide direction to prioritize the use of current resources for analytics of the UT Data Center data.

Prioritization should be given to directing UT Data Center to aggregate all available clinical, claims, pharmacy, cost, and quality data regarding specific high cost/high prevalence conditions, such as diabetes, to develop additional features and de-identified data files for public and research use. Also, the data could be used to establish benchmarks to better understand prevalence, interventions, and payments for treatment for chronic conditions to facilitate collaborative quality improvement efforts on the part of state payers and providers. Multi-payer claims data can also enable better health care consumer decision-making through insights into provider and facility cost and quality variation.

Other states have benefitted from their existing APCDs in making applications for federal funding opportunities to test health care innovations. For example, CMS has embraced the use of multi-payer data as a tool in its Comprehensive Primary Care Plus (CPC+) model designed to transition primary care from fee-for-service (FFS) to a value-based structure. CPC+ includes not only Medicare FFS but also 56 partner payers in Medicare Advantage, Medicaid and commercial insurance. Seven among the CPC+ regions aggregate data with program objectives to reduce provider burden and improve insights through comprehensive data on patient populations, improve regional payer alignment around key measures and data sharing initiatives, and increase use and usefulness of aggregated data reports to drive better care, lower costs, and improve health. Four of the CPC+ data aggregation regions go beyond claims aggregation to also integrate clinical, ADT, and/or SDOH data. These aggregation regions may also be used as models to consider how the integration of varying types of data can support transformational, value-based initiatives through more timely and actionable data.

There may be additional federal funding opportunities that leverage multi-payer data sources soon, including in the rural health care space. CMS has recently launched a Rethinking Rural Health Initiative and among its focuses are rural maternal health, rural hospital reimbursement, and rural APMs.⁷ CMS also partnered with Pennsylvania on the Pennsylvania Rural Health Model, which implemented a global payment for rural hospital inpatient and outpatient care.⁸ Finally, CMS just announced the Community Health Access and Rural

⁷ Verma, Seema. CMS. *Rural Health at CMS: What's Been Done and What's to Come*. Retrieved at: <https://www.cms.gov/blog/rural-health-cms-whats-been-done-and-whats-come>

⁸ <https://innovation.cms.gov/innovation-models/pa-rural-health-model>

Transformation (CHART) Model with an accountable care organization track and community transformation track. In the community transformation track, a lead entity, in collaboration with community partners and aligned payers, develops a Transformation Plan with a rural health care delivery redesign strategy.⁹ Texas would be an ideal state to test rural funding models that possibly include rural health clinics as well. Until recently, Texas has not been able to leverage multi-payer data to avail the state of federal matching funds to support VBP transformations. Texas should consistently assess opportunities to pursue federal matching funds for VBP initiatives such as those sponsored by entities such as the Center for Medicare & Medicaid Innovation and leverage its new multi-payer analytics capacity in making application.

Leveraging the Texas Healthcare Learning Collaborative Portal and Other Data Sources

The Texas Healthcare Learning Collaborative (THLC) portal is a strong, public-facing tool that provides data on Medicaid MCO and dental contractor (DC) performance, including on potentially preventable events, medical and dental quality of care measures, and CMS core measures.¹⁰ Information is available in dashboards that can be searched by year, program type, MCO, and measure set, and the aggregated data may be downloaded. THLC data is primarily used by HHSC, MCOs, and DCs, though it can also be accessed directly by providers, enrollees, and other stakeholders.

The November 2018 VBPQI Report included the following recommendation:¹¹

“HHSC should work with stakeholders to better leverage the Texas Healthcare Learning Collaborative portal (and other tools as appropriate) to increase and improve the data available to health plans, providers, and policy makers for core metrics, analytics, and care coordination to support value-based purchasing and quality improvement, including by:

- a) Enabling providers to see their performance on core measures to benchmark against other Medicaid providers.
- b) Enabling the sharing of historic patient-level data over time, as enrollees move in and out of Medicaid and between plans and providers (similar to the type of information included in the STAR Health Passport – user-friendly list of history of medications, diagnoses, immunizations, etc.).
- c) Adding more data by health plan on cost and utilization trends to the portal.”

The opportunity remains to grant providers access to their own outcome data to enable them to compare their performance to state and regional benchmarks of

⁹ <https://innovation.cms.gov/innovation-models/chart-model>

¹⁰ <https://thlcportal.com/home>

¹¹ <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/value-based-payment-qual-improvement-recommendations-nov-2018.pdf>

similar providers, manage patient care, and assess opportunities for value-based purchasing. The opportunity also remains to include protected access to longitudinal, patient-level data that would facilitate continuity of care and care transitions even when patients move or switch MCOs.

This report expands on these opportunities to recommend exploration of new potential use cases for the Texas Healthcare Learning Collaborative Portal and other data sources. One such use case may be to leverage all the available data within THLC, the UT Data Center, the Texas Health Care Information Collection (THCIC) and other data to focus on a specific high-incidence condition like diabetes not only in Medicaid but also among other state payers. Another use case may be to leverage data in THCIC on uncompensated care provided in hospitals to identify any more granular information that could be discerned about care and health of the uninsured population.

The potential use cases developed should then be analyzed for the value they bring to advancing health care in Texas, and a strategy should be developed to implement the most valuable and feasible use cases. During this process, Texas should clearly delineate the roles and responsibilities of each data source (i.e., THLC, THCIC, UT Data Center, etc.) so that health care data consumers understand which data source is the access point for each purpose and there is not duplication of resources. Consideration should be given to the strengths of each existing data tool, their existing authorities for data use and dissemination, and how to minimize disruption or confusion among the existing base of consumers for each data source.

Other State APCDs

Texas can look to several other states for examples of potential uses of APCDs. States are using APCDs to enable insights into the relative health of their populations, including regional variations. They can demonstrate trends in utilization and spending, showing how health care resources are allocated from the standpoint of preventive care versus interventions for preventable conditions. Such efforts can reveal areas of wasteful health care spending, opportunities for quality initiatives, and opportunities for payment reform. From the consumer standpoint, APCDs can assist in understanding variations in cost and quality among providers.

For example, in its 2019 report on *Facilitating Use of data to Drive Population Health in Texas*, the Texas Health Improvement Network (THIN) cited Colorado as an exemplary APCD model for its balance of public governance and external expertise.¹² The Colorado APCD's appointed administrator is a non-profit organization, Center for Improving Value in Health Care (CIVHC), which receives significant grant funding for its operations. It was developed through a legislatively established advisory committee charged with supporting the database in its mission and subsequently making key recommendations on its operations.¹³ The APCD also

¹² https://utsystem.edu/sites/default/files/sites/texas-health-journal/new%20site/THIN_Facilitating-Data-Use-For-Population-Health_Mar2019.pdf

¹³ Colorado [Senate Bill 13-149](#)

has a Data Release Review Committee that develops protocols for data release and reviews request for data. The CIVHC holds quarterly meetings to discuss ways to transform health care and convenes stakeholders for more specific initiatives that can be informed by the data, such as palliative care, care transitions, and episodes of care.

CIVHC developed and maintains a publication library of reports that have used the APCD data. It also has a clear process for custom data requests and an easy-to-use interface for the public to generate infographics and key data of interest with county-level mapping or facility-level data where applicable. Examples of the public information available through CIVHC follows:¹⁴

- Pricing of common procedures and imaging at facilities and the facilities' quality ratings, enabling viewing of pricing ranges (variation) and medians
- Per person per year costs by geography, payer and service type, including cost trends
- Condition prevalence for major conditions, like asthma, COPD, cancer, depression, and hypertension, by geography and payer
- Analysis of low-value care
- Analysis and data for out-of-network care
- Quality measures, including A1c testing, cancer screenings, and asthma treatment, by geography and payer type trended
- Reference pricing for commercial services as a percentage of Medicare fee-for-service by region
- Utilization, including unplanned hospitalizations, ED visits, 30-day readmissions, observations stays, outpatient services, pharmacy scripts, and generic pharmacy scripts

Maine has used its APCD to enhance pricing transparency for consumers with search functionality that yields facility-specific quality ratings and facility-specific cost information by procedure and payer.¹⁵ Maine also features cost driver analyses that can be refined by county and coverage type. The drug data analysis identifies top 25 lists for the costliest drugs, most prescribed drugs, and drugs with the highest year-over-year cost increases. Other data includes hospital financial status and top utilized services, including physician, outpatient hospital, and inpatient hospital DRG. The Maine APCD site features a process for researchers to request customized reports or raw claims and other data files.

The Massachusetts APCD has less data immediately accessible to the public researchers, but the data available by request is robust.¹⁶ Massachusetts will create extract files from the APCD in five to seven business days. Case Mix Data includes inpatient, outpatient and emergency department data. Acute hospital case mix data includes case specific, diagnostic discharge data that describe socio-demographic

¹⁴ <http://www.civhc.org/get-data/public-data/>

¹⁵ <https://mhd0.maine.gov/>

¹⁶ <https://www.chiamass.gov/data-index/>

characteristics of the patient, the medical reason for the admission, treatment and services provided to the patient, the duration and status of the patient's stay in the hospital, and the full, undiscounted total and service-specific charges billed by the hospital. Insurance and coverage data includes enrollments data and premiums and cost-sharing. Researchers can use public information requests to receive payment and expenditure data on total medical and health care expenses, APMs, provider payment methods, relative price, and network average relative price dollar amounts. Through its APCD site, Massachusetts also enables public information requests for various cost reports and provider financials (e.g., hospital financials and cost reports for hospitals, nursing facilities, adult day health, and community health centers).

The Medicare Diabetes Analysis generated from the Arkansas APCD is an example of how APCD data could be used to generate detailed analyses of chronic conditions for aggregate or individual payer types.¹⁷ This analysis uses the APCD to produce diabetes prevalence and complications data, enabling mapping of hot spots by complication and county. Review of the data on diabetes complications enabled the state to propose further research into solutions to reduce specific complications. For example, Arkansas determined data from the APCD could be used to assess if the geographic distribution and capacity of designated “stroke ready” hospitals meet the access needs expected based on county-level population and disease burden estimates for people with diabetes who experience ischemic stroke.

¹⁷ <https://www.arkansasapcd.net/Docs/166/>